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Amish Femininity: New lessons from the Old Order

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Feminist scholars continue to be interested in how society mediates the bodily experience of pregnancy and childbirth (Boyacioglu 2008; Carter 2009; Fisher, Hauck and Fenwick 2006; Pranee Liamputtong 2005; Mansfield 2008). In short, “birth matters”(Gaskin 2011, p. 1). Yet there has been much debate around why and how it matters, since “reproduction has been, is, and will in all likelihood continue to be charged with intensifying politics of hope and despair, pleasure and danger for individuals, collectivities and societies, [and for that reason remains] a site worthy of our sustained concern”(Clarke 1995, p. 151). I build from Clarke’s claim that reproduction is a site worthy of our sustained concern, and consider how meanings associated with birth – including labor, delivery and pain – might be influenced by specific conceptions of femininity. How might the norms of femininity, particularly those that reward women’s passivity and enforce a “tyranny of nice and kind” (Martin 2003), manifest in a woman’s particular experience of birth? Further, I examine as a counterpoint how norms associated with Amish femininity shape Amish women’s experience of birth. I present an ethnographic account of three aspects of Old Order Amish birth based on the criteria developed by Brubaker and Dillaway (2009) by considering (1) details of the *birth setting*, (2) issues of *control*, and (3) how the *use of medical technology* (or lack thereof) may influence women’s birth experience.

Doing so illuminates how Amish women *do gender* (West 1991) during childbirth. Because norms associated with Amish femininity differ from those associated with mainstream American femininity, approaches to and experiences of birth appear quite different in the two contexts. I draw on two years of participant-observer data collected at Amish births to show how practices such as unmedicated homebirth come to possess specific social meaning for Amish women, and are tied to how Amish women *do gender*. I further suggest that these practices are animated by a conception of femininity whose architecture rests on cornerstones quite different from those anchoring mainstream American femininity. To explore the consequences of these differences in normative gender expectations, I offer a comparative analysis of Amish and mainstream American birth practices. Brubaker and Dillaway remind us of the importance of undertaking comparative work such as this, and advise that:

"We need to conduct comparative research on the subjective experiences of pregnant and birthing women at multiple social locations and in multiple contexts, as well as on the experience and perspectives of midwives and medical providers in order to provide a more critical and meaningful analysis of the complicated intersections of ideology, politics, practice and bodily experiences" (Brubaker and Dillaway 2009, p. 45).

Brubaker and Dillaway compel researchers to consider both the differences between and the similarities across women birthing in different social locations. My goal – through a comparative analysis of birth in two settings – is to demonstrate that social expectations related to gender performance stubbornly permeate women's understandings of, approaches to, and experiences of birth. I am interested in how ideas shape experiences. As Brubaker and Dillaway have suggested, what this means in terms of specifics varies greatly by social location. An analysis of

my data suggests that the Amish's novel conception of femininity might serve as an augury of a similarly novel approach to and experience of birth.

Thinking about *Doing Gender*

Sociologists have long contended that “gender itself is constituted through interaction” (West 1991, p. 129) and that gender is “an ongoing activity embedded in everyday interaction” (West 1991, p. 130). Gender is accomplished interactionally through “a set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, of a natural sort of being” (Butler 1999, p. 43). So despite being seen as *natural*, gender is perhaps better characterized as a set of scripted social interactions that, when performed properly, convene membership into one of two gender categories. These categories have come to encompass the interactional ways that femininity and masculinity are performed. And though multiple femininities and masculinities do exist, so too exists a singular, or hegemonic, form. As such, gender performances become calcified along prescribed pathways, limiting the degrees of freedom an individual has to *do gender*. Hegemonic femininity emphasizes interactions that incorporate elements of deference and submission (Ussher 1997), thereby creating an environment where women who perform femininity with punctilio reap the social rewards, while those who do not face a more censorious set of social sanctions.

The social capital afforded to feminine women is hard to ignore (Bordo 1993). That is not to suggest that women do not (or cannot) perform gender in non-normative ways, but to instead recognize that a woman's gender performance is not entirely voluntary (Bordo 1993; Butler 1999). A woman's inclination to resist the directives of normative femininity may be held

hostage by the threat of social retribution. By refusing to engage in appropriate gender performance, women risk being labelled unfeminine and losing social standing, often making the only choice gender conformity. “Masculinities and femininities, while performative in nature, are not arbitrary” (Paechter 2007, p. 40) and social context outlines both the possibilities of what can be performed as well as demarcates the boundaries of those performances. Across milieus, women comply with gender mandates and *do gender* in normative ways. These performances surface even when engaged in pursuits conventionally coded as masculine, when *doing gender* serves as a hindrance rather than a help. Such paradox arises anywhere from the athletic field (Krane 2004) to the physics classroom (Danielsson 2011) and these moments make visible gender’s constricting nature. Those experiences that require physicality, body confidence, assertion and other qualities not conventionally coded as feminine showcase gender’s carapace and make for sites of analysis at a breach. Birth is one such moment, and it is worth considering how women reconcile the physical demands required of birth with the docility and the pageantry of weakness celebrated by normative femininity. Such an inquiry leads to another: does an alternative conception of femininity – specifically one that rests on a woman’s physicality and strength – portend an alternative experience of birth?

Study Sample and Method

This study draws on an ethnographic analysis of birth within several Old Order Amish communities. Of interest were Amish women’s particular experiences of birth, and the meanings these women associated with labor, delivery, pain and the practice of unmedicated homebirth. Equally intriguing was how Amish women’s birth experiences related to a culturally specific

construction of Amish femininity. To conduct this research, I served as an apprentice midwife and volunteer healthcare worker for two and a half years. In this capacity, I attended 40 Amish homebirths as well as several hundred prenatal visits. As an apprentice, I provided birth care assistance to a senior midwife. This midwife, who was not herself Amish¹, served as my gatekeeper and as a point of triangulation in my data analysis, meeting my questions and observations with 20 years of midwifery experience serving Amish women. In the 30 months that I spent collecting data, I participated in Amish pregnancy and birth care, providing labor support, prenatal and postpartum care to birthing women and their families. Acting as a participant observer normalized my presence in Amish life, and allowed me to draw on local phenomena to understand broader social processes (Eisenhardt 2002). In this capacity, I was able to take part in a unique set of birth practices and had an opportunity to more deeply understand the meanings that these practices have for Amish women, their families and their communities. Being actively involved in prenatal care, labor and delivery, and the post partum treatment of Amish women made it possible to gain a more holistic appreciation of what birth means, and “instruct[ed] [my] everyday knowledge of how the world works” (Smith 1987, p. 182).

I analyzed data gathered from my ethnography of Amish birth alongside mainstream birth practices, and explored them through an examination of patterns and more general trends in American birth care. I offer a review of the movement towards medicalization in American mainstream childbirth and detail some of the specific birth practices that coincide with this tendency. Juxtaposed is an examination of Amish women’s approach to birth, along with a consideration of the unique features of unmedicalized, midwife-attended homebirth. Putting

¹ For more information on why Amish women use non Amish midwives, see (Jolly 2014).

Amish women's birth experiences into conversation with mainstream American approaches to birth illuminated the importance of social location. Amish women *do gender* differently, and thus *do birth* differently, all of which offered insight into how femininity shapes a woman's experience of birth.

Findings

Research into the Birth Setting

For most women, “being a responsible person means accepting the authority of scientific-medical discourse, and being a good mother means seeking to minimize risk through reliance on doctors’ expertise” (Miller and Shriver 2012, p. 712). In the context of mainstream birth, this means delivering in a hospital, with care overseen by an obstetrician. The transition from “almost all births taking place at home to almost all births taking place in the hospital took just two generations” (Rothman 1982, p. 29). During that time, birth was reconceived as a medical event to be managed, and a high level of medical intervention now characterizes labor and delivery (Jolly 2010). In their third national *Listening to Mothers* survey of 2400 new mothers across the U.S., Declercq et al. found that the women surveyed reported that obstetricians were most likely to serve as primary birth attendants (70%), more than 4 out of ten respondents indicated that their care provider tried to induce their labor, that the vast majority of women (83%) reported using one or more types of medication for pain relief, and nearly one in three delivered via cesarean section (Declercq et al. 2014). Various critiques have been leveled against both these specific medical practices and the general trend towards an increasing medicalization of birth, ranging

from “the lack of control accorded to women throughout the process” (Miller 2009, p. 52) to the casting of pregnancy and birth as disease (Martin 2001).

Amish birth exists in sharp contrast to non-Amish birth practices in North America.² Amish births took place in the home and were attended by a direct-entry midwife who was often not herself Amish. Laboring women were unmedicated and deliveries were marked by a lack of medical intervention. As opposed to their mainstream American counterparts, Amish women in labor did not wear hospital gowns, were not restricted to bed, did not fast during labor, were not exposed to continuous monitoring technologies, and experienced very few interventions of any kind (Davis-Floyd 1992). Instead, their labors were marked by the non-medical environments where they occurred. The Old Order population examined here eschewed technological innovation, individual ownership and attention to fashion in favor of a “simple life” involving an agricultural or rural lifestyle (Kraybill 2001). Framed by a traditionalist Christian faith, Amish society remains highly gendered, with women overseeing childcare and domestic work while men take responsibility for paid work and church leadership. Houses lacked electricity, dress was distinctly “plain” (with bonnets, dark colored dresses and black aprons for women and black pants, dark colored button shirts and hats for the men) and transportation was largely limited to horse and buggy. And though there existed some flexibility in the operationalizing of these mandates (Kraybill 2001) (drivers may be hired for long distance travel, a propane or diesel generator could be used to operate kitchen appliances, etc.) there was a collective desire to pursue a life “in this world, but not of it” (Hostetler 1993).

² Amish births in this study happened in rural locales across central Pennsylvania. The study site focused on several small valley communities to the east of State College, PA, including Brush Valley, Penns Valley, and Nittany Valley.

Two features of Amish birth became salient in my analysis of midwifery in Amish communities. First, Amish women were particularly active during labor and delivery, and their actions took the form of conventional caregiving work associated with normative femininity. A laboring woman would help with meal preparations if she was able, and could often be found doing small tasks such as hanging up laundry or sweeping the floor to pass the time during her labor. Amish labor was characterized by a desire to stay busy and not sit down, especially during early labor. Tasks that involved squatting or kneeling were popular, and several women cleaned the floor on hands and knees while in early labor. I observed Amish women walking, gardening, bathing, cooking, cleaning, and even singing while in various stages of labor. Second, Amish women characterized this behavior as normal and it fit within a more general Amish discourse about work. For Amish women and men, hard work is celebrated and venerated, “[w]ork is not just a way of getting something done; it makes a statement about one’s faith and identity” (Kraybill and Bowman 2001, p. 199). Kraybill wrote about the *Ordnung*, calling it the “rules and discipline” of Amish life, and noted, “[t]hese rules for living, which developed over the generations, provide a blueprint for an orderly way of life” (Kraybill 2001, p. 15). One such tenet of the *Ordnung* is this notion that, “[w]ork is more satisfying than consumption” (Kraybill 2001, p. 19) and that “labors that produce a tangible result” are always more valued over those that do not (Kraybill and Bowman 2001, p. 194). Birth was viewed as an opportunity for a woman to engage in hard work with a tangible result, and engaging in the work of unmedicated labor and delivery made a statement about her faith and her identity as an Amish woman. The opportunity to labor and deliver while at home gave Amish women access to a currency highly valued within their world; being Amish was bound up in the practice of unmedicated homebirth. As Liamputtong reminds us, “the social meaning of birth is shaped by the society in which birthing

women live” (P Liamputtong 2005, p. 244) and for Amish women, labor (both during childbirth and otherwise) was an integral part of Amish femininity.

Control

Compared to their non-Amish counterparts, Amish women exercised a high level of control over their pregnancy and birth experience. An Amish woman saw herself (and similarly was seen by her midwife) as the voice of authority on her body, her pregnancy and her birth. In many ways, the Amish women involved in this ethnography played an active role in parturition. This was most obvious in the degree to which partnership marked the relationship between midwife and client. Mutuality was actively cultivated, and both parties regularly made requests of each other. The midwife might give her client the option to change positions, ask her preference about when to do an uncomfortable procedure, or even inquire if she feels ready to push during the final stage of labor; with full expectation that the question did not foreclose a woman’s ability to express honestly her consent or dissent. This mirrored the practice of non-Amish midwifery, where birthing women are understood to be “potentially knowing, capable, and strong, their bodies perfectly designed to carry a fetus and to give birth successfully without the high-tech surveillance and interventions of physicians in a hospital setting” (MacDonald 2007, p. 96). Though, in a departure from standard midwifery care, Amish women often asked their midwife for small favors, such as to deliver something on her next visit or run an errand. They would not hesitate to ask a midwife to move her car, move in from the porch, or otherwise conceal her presence at a birthing woman’s house³; and would often seek a midwife’s council on matters

³ Amish women do not disclose their pregnancy and seclude themselves from others when visibly pregnant. See (Jolly 2014) for more information.

ranging from local Amish kinship patterns to how to achieve long-term sexual satisfaction (Jolly 2014). Many of these practices fell outside the norms of conventional healthcare provider/client relationships, and, as a result, these ongoing transactions, interactions and negotiations knit control between the two parties.

Understood this way, control was not manifest as the midwife having power over the birthing woman, but was instead manifest as power-to, capacity, can-ness, “the human ability not just to act but to act in concert” (Arendt 1970, p. 44). The midwife serving her Amish clients recognized that her position was much more in line with midwife’s etymology, meaning *with women*, and saw her position as one of support and care-giving. This is not to suggest that she provided no medical assistance, and indeed I observed and assisted her during births that required her to stop a severe hemorrhage, deliver surprise twins, revive a listless baby, free a stuck baby (shoulder dystocia), deliver a dwarf baby, perform a VBAC (Vaginal Birth After Cesarean), and transfer to a hospital on occasions when it became medically necessary. Despite valuing her skill and training, her Amish clients did not see their midwife as having authority over them and did not overtly defer to her. Instead, a woman would labor on her own, often in another room and accompanied by her husband, and seek out her midwife only when delivery impended. For her part, the midwife listened closely to her clients, and knew them intimately enough to be able to assist them without assuming control over the pregnancy and delivery.

Hanna Pitkin writes that, “[p]ower is capacity, potential, ability, or wherewithal” (Pitkin 1972, p. 276) and in observing Amish women interact with their midwife, what became apparent was the degree to which both shared in control over the birth process. Power was constituted as “the ‘horizontal’ development of *power together*” or *power with*, rather than “the ‘vertical’ operation of *power over*” (Tew 2006, p. 40). For Amish women and their midwives, “[p]ower

with relations reflect[ed] an empowerment model where dialogue, inclusion, negotiation, and shared power guide[d] decision making” (Berger 2005, p. 6). This relationship differed from the one characterized by modern obstetrical care, and the Amish women we served expressed some anxiety about the (albeit, slim) potential for hospital transfer.⁴ In an interview done with an obstetrician practicing in this geographic region, the doctor noted that Amish women were her “most compliant patients” and did whatever a doctor asked of them.⁵ Such compliance did not characterize Amish women’s interaction with their midwife. Despite her extensive medical training and decades of experience, the midwife was not seen as a doctor by her Amish clients. Viewing her as neither a doctor nor a layperson fostered a relationship where decision-making and control could be shared between the two. Power resided in neither the midwife nor solely in the birthing woman, but instead comingled between the two and allowed both to fashion a synergistic relationship marked by ‘reciprocity and mutuality’ (Arendt 1963, p. 181).

Technologies... from medicine to gender

Midwives serving Amish clients brought little in the way of medical technology to pregnancy care and birth. Ultrasounds were not performed unless a problem was detected, blood was not drawn, a woman’s weight was not evaluated, genetic testing was not offered. Instead, prenatal care involved the midwife listening to the fetus’ heartbeat, palpating for fetal positioning, evaluating a woman’s urine for anomalies, and measuring fundal height (a surface measure of the abdomen from pubic bone to top of uterus to roughly gauge fetal size). Labor and delivery did not involve continuous fetal monitoring or other technologies of fetal or maternal

⁴ Less than 5% of the midwife’s clients were transferred to the hospital for care.

⁵ The obstetrician was one of three who staffed the local hospital. She compared her Amish patients with her non-Amish patients, remarking on the striking degree to which Amish women acquiesced, comparatively. She noted that, “The worst are the women from the University.” She found these women to often be non-compliant, and sometimes aggressively so, a comment that the readers of this journal will likely find particularly humorous.

surveillance, pain medications were not administered, regular vaginal evaluation of cervix dilation was not performed. An Amish woman generally birthed in a supported squat using a birthing stool with her husband seated behind her. Births also occurred on the bed, in the bathroom, or on occasion in the dining room/eat-in kitchen, depending on a woman's preference. Once born, the newborn was passed to the mother, and the placenta was delivered without intervention. Only once the cord ceased pulsing would it be severed, a task usually performed by the baby's father. Cold compresses and aspirin were offered to the mother for residual pain, but no other treatments were administered.

Instead of a focus on specific medical technologies (or lack of), I suggest that the more salient technologies that surfaced during pregnancy and birth were the internalized technologies of gender. Martin defined internalized technologies of gender as, "those aspects of the gender system that are in us, that become us" (Martin 2003, p. 56) and suggested that understanding gender as an internalized technology is significant because it "produce[s] who we are, even during seemingly natural experiences like birth" (p. 57). Drawing on Foucault's (1977) notion of technologies of the self, Martin demonstrated that normative forms of femininity discipline women. She concluded that a *tyranny of nice and kind* shaped women's behavior, even during delivery.

The women express selves that are relational, selfless, caring, polite, and subjected to the tyranny of nice and kind. This gendered identity led them to expend much energy on taking care of others and obeying gendered social norms about politeness while they were in the middle of a profound physical experience that takes considerable energy, agency, and willpower. Technologies of gender kept these women compliant

and let them not to ask for what they needed for fear of asking too much of others
(Martin 2003, p. 69).

And because gender expectations differ across social location (Connell 1987), the normative forces that operate on Amish women differs substantially from the *tyranny of nice and kind* that worked on the mainstream American women interviewed by Martin. “Women’s childbirth choices are heavily shaped by gendered technologies of power” (Chadwick and Foster 2013, p. 332) and for Amish women this meant that discourses around the specific formation of Amish femininity warranted evaluation, as they differ from the discursive framework experienced by women previously studied (Martin 2003) (Chadwick and Foster 2013). In short, Amish women *do gender* differently, and this manifested in their experiences of birth.

Gender norms that characterized Amish women as capable and competent allowed them to see labor and delivery as something that they could successfully accomplish. Amish women approached childbirth without fear of pain and instead equated the noun *labor* with the verb *labor*; they likened it to hard work rather than to agony and suffering. Surrounded by a society that valued women’s labor (in childbirth and more generally), Amish women found authenticity in their desire for and pursuit of an unmedicated homebirth. After all, “women tend to want what the society values” (Klein 2006) and Amish society lauds women’s fortitude. To be an Amish woman meant to confront the physicality of birth unflinching and to triumph in the face of physical exertion. For the Amish, as for the rest of us, birth is a “socially embedded experience” (Behruzi et al. 2013, p. 206) and one that is “internally consistent and mutually dependent [on] practices and beliefs that exist around it” (Jordan and Davis-Floyd 1993).

Drawing conclusions from Amish femininity

Despite its patriarchal and biblical underpinnings, Amish femininity nonetheless features cultural particularisms of interest to scholars curious about the social construction of gender. First, Amish lack exposure to mainstream American culture resulting in a high level of body confidence.

Amish women do not suffer from dysmorphic body image (Platte and Zelten 2000), do not experience eating disorders, and are not exposed to a *cult of thinness* (Hesse-Biber 2006) which privileges slim bodies over strong ones. Instead, the Old Order Amish women we served shared an assurance in their body's ability to accomplish a variety of physically difficult tasks, including the work associated with pregnancy and birth. Such assuredness grew out of a discursive framework that privileged competency over aesthetic, and was embedded in a culture that venerated women's hard work. Interleaved was a conception of physical exertion as an integral component of women's work. The physical pain associated with labor and delivery at home was not seen as something to fear or avoid, but instead offered Amish women an opportunity to comply with the edicts of Amish womanhood and "do normative femininity" (Chadwick and Foster 2013) within an Amish context.

The directives of Amish normative femininity did more than simply refigure the meaning of pain and hard work during labor and delivery. Norms around unmedicated homebirth coincided with Amish women laboring in a setting over which they held considerable sway (in their own home) (Carter 2009) and being attended by a medical caregiver with whom they had cultivated a longstanding relationship of shared power. "Birth is everywhere socially marked and shaped" (Jordan and Davis-Floyd 1993, p. 1), and for Amish women, childbirth choices were inexorably tied to ways of doing normative femininity within Amish society. As a result, we begin to see that "childbirth is part of a complex gendered process" (Chadwick and Foster 2013)

and that “women’s birth experiences are regulated by other social mechanisms, namely internalized identities and especially, in this case, gendered identities” (Martin 2003, p. 69). Technologies of gender kept Amish women from desiring a medical birth and instead shaped their aspiration for an unmedicated homebirth.

Implications

“How do women experience childbirth today?” asks Akrich and Pasveer (2004, p. 63). If we are to attempt an answer, we must consider “a more critical and meaningful analysis of the complicated intersections of ideology, politics, practice and bodily experiences” (Brubaker and Dillaway 2009, p. 45). The Amish provide one such vantage point, and offer insight into what an alternative conception of femininity might engender in terms of specific birth practices. A discourse of femininity that values work, body confidence and shared power may produce an environment where the work of labor is equated with accomplishment rather than something to be avoided. And while it would be impossible to “carry out practices lifted out of one cultural context and inserted in another” (Buskens 2001, p. 82), these findings nonetheless provide a window into the consequences of configuring what it means to be feminine in an alternative way. *Doing gender* in a social context where femininity is equated with body confidence and an ethic of hard work goes part of the way towards creating an environment where women can *do birth* differently.

Many are pondering the consequences of rising rates of medicalization in childbirth (Anim-Somuah, Smyth and Howell 2011; Beckett 2005; Anderson 2004; Bryant et al. 2007; Green and Baston 2007; McAra-Couper, Jones and Smythe 2010) and mainstream women’s

attendant fear of pain associated with birth (Bewley and Cockburn 2002; Eriksson, Westman and Hamberg 2006; Fisher, Hauck and Fenwick 2006; Haines et al. 2011; Nilsson and Lundgren 2009; Stoll and Hall 2013). Such discussions must reckon with the culturally specific ways in which mainstream women *do gender*, as a woman's embrace of medicalization is inexorably tied to a conception of femininity that casts her as passive, fragile and helpless. This was not true for Amish women, and laboring at home and unmedicated became a way for Amish women to conform to the normative parameters of Amish femininity. In Amish society, both women's bodies and their minds were cast as capable, and as a result the strength and the pain tolerance unmedicated homebirth required did not exist in opposition to an Amish conception of femininity but instead became emblematic of it. Because mainstream femininity is constructed along different lines, women's labor (both generally, in terms of effortful work and specifically, in terms of the three stages of birth process) does not carry the same social currency. Normative femininity in Western society devalues a woman's ability to endure pain, to work hard, and to prevail in the face of adversity. Instead, normative gender expectations celebrate a woman's rescue from difficult situations and I suggest that this has material consequences for her conceptualization of pain, her understanding of labor, and her bodily experience of birth. That mainstream women might see pain, work, and the indignities of unmedicated vaginal birth as unfeminine should be of little surprise in a culture of femininity that inoculates women against a sense of body- and self- confidence (Jolly Forthcoming). For mainstream women, *doing gender* correlates with birth experiences that are highly medicalized and increasingly surgical.

Certainly pain and physical labor are not necessary vehicles for a liberatory birth experience, nor should this argument be read as a paean to vaginal delivery, homebirth, or unmedicated labor. The aim here is merely to suggest that the underlying social features of

mainstream femininity may enable medicated (and increasingly surgical) birth to have such cultural purchase. When Martin asks, “How does birth look through the eyes of women?” (Martin 2001, p. 139) we would be wise to consider that women’s eyes have been socialized to see birth through a culturally specific lens; gender ideologies shape birth experiences. To fully answer this question, research needs to continue asking how discourses of femininity shape embodied gender subjectivities, as these discourses have very real material consequences for women’s bodily experiences of childbirth.

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